MARICOPA INTEGRATED HEALTH SYSTEMS – HEALTH PLANS
PROVIDER INFORMATION FORM

Completion of the Provider Information Form ensures that MIHS has the most current information about you and your practice in our provider database and provider directories. This information provides the most current information with regards to claims payment. Please complete and return this form ASAP. Should you have any questions regarding this form, please contact our Provider Services Department at 602-344-8957/Fax 602-344-8933.

Full Name (Last, First, MI, Degree) **AHCCCS ID Number**_____ **Date of Birth:**_____ **SSN;**_____	**Group/Corporate Name, if applicable** **Office Manager Name**:_____ **Telephone Number:**_____
Enter Specialty*:* _____	***Check one:*** ____ **PCP** ____ **Specialist**

Business Address #1:	**Mailing Address:**
Full Street Address:	**Full Street Address**
City, State, Zip:	**City, State, Zip:**
Telephone w/ Area Code:	**Telephone w/ Area Code:**
Fax Number:	**Fax Number:**
Tax ID Number (TIN)	

Covering Physicians(s)

Physician Name	Specialty	Telephone Number

THIS IS A TWO-SIDED DOCUMENT

YOU MUST COMPLETE AND SIGN THE BACK PAGE

Business Address #2:	Mailing Address:
Full Street Address:	**Full Street Address**
City, State, Zip:	**City, State, Zip:**
Telephone w/ Area Code:	**Telephone w/ Area Code:**
Fax Number:	**Fax Number:**
Tax ID Number (TIN)	

Covering Physicians(s)

Physician Name	Specialty	Telephone Number

HOSPITAL PRIVILEGES

1)	**3)**
2)	**4)**

LANGUAGES SPOKEN IN OFFICE

By Practitioner:	By Office Staff:

By signing below, I hereby attest that all information provided is complete and accurate.

Signature **Date**

Printed Name **Date**

Please fax to MIHS-HP Provider Services at 602 344 8933